services to more systematically target social needs and to share power through partnership working may reduce the mistrust that many with psychosis feel when entering services and in turn reduce persistent inequalities across ethnic groups.

13 BUILDING TRUST IN CLINICIAN-DETAINEE INTERACTIONS: THE ROLE OF A BOUNDARY OBJECT

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10.1136/bmjopen-2021-QHRN.51

Background Detainees in Immigration Removal Centres (IRC) report distrust in interactions with staff and Home Office officials.¹ Clinicians volunteering with NGOs offer independent medical assessments and write medico-legal reports to support detainees' asylum claims. Outcomes could be impacted if insufficient trust is established, or if distrust develops, when discussing traumatic experiences that can recreate positions of powerlessness and vulnerability. The complex dynamics of trust-building with detainees have seldom been explored in IRC contexts, which typically preclude researchers' direct access.

Aim To identify processes that enable trust-building in clinician-detainee interactions in an IRC in England, using the qualitative tool of autoethnographic reflection.

Methods I explored my own practice as a volunteer physician undertaking clinical assessments with detainees over a two-year period, through reflexive autoethnography. I used the conceptual lens of boundary-spanning work² to explore trust-enabling processes within the particular social context of my interactions with detainees.

Results As detainees shared emotional accounts of traumatic experiences, collaborative navigation of uncertainties replaced the traditional 'history-taking' performative of clinician-led interactions. The intended transformation of a narrative into a medico-legal report allowed an intermediary platform between detainees' telling of individual experiences and my re-telling in the form of the 'expert evidence' required for asylum claims.

Conclusion The objective of generating content for a detainee's medico-legal report differs from the 'usual' circumstances of a medical assessment. Reciprocal processes of narration can rechannel power asymmetries inherent in the interaction, co-constructing some form of agency. Boundary objects between forms of knowledge might offer a platform for building trust in precarious clinical interactions.

REFERENCES

1. Kellezi B, et al. Understanding and coping with immigration detention: Social identity as cure and curse. *Eur J Soc Psychol* 2019;**49**:333–51.
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Day 2: Friday 19th March – 14.50-15.50

14 TRUST AFTER AVOIDABLE HARM IN MATERNITY CARE: THE POSSIBILITIES OF ETHICAL AFFORDANCE

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10.1136/bmjopen-2021-QHRN.52

Background After incidents of harm in healthcare, trust in systems and in individuals is at risk. Most harmed families seek open discussion, information and empathy. When clinicians seek to provide this, they envisage risk of harm to themselves and reputations, professional investigation or litigation.

Aims To examine: (a) family expectations of communication following serious incidents and communication constraints felt by clinicians; (b) how some clinicians manage this work; (c) the impact of extensive NHS initiatives to support this work.

Methods Thematic analysis of over 40 in-depth interviews with maternity staff and service-users.¹

Findings We identify three dimensions of actual incident management events described by clinicians. These are: (1) apology; (2) information sharing; and (3) ongoing relationships. We develop Keane's²(2016) concept of 'ethical affordance' to understand how clinicians make situated judgements and negotiations of risk to themselves and their colleagues. Affordance involves the open-ended, anticipatory and opportunistic reflective work involved in everyday ethical practise. Contractual and relational aspects of communication with families are negotiated in this way.

Overall, however, these practices are constrained by the contradiction between healthcare policies, promoting openness and trust, and primary legislation, encouraging suspicion. This constraint is felt most acutely when staff are mistrustful of their own organisation and where responsibility for incidents is often individualised.

Conclusion Support of harmed families requires complex skills, including ethical affordance. Considerable investments in high-level safety improvement has effect only in those services where clinicians feel safe and skills can be developed.

REFERENCES

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15 GENDER-BASED STIGMA AND ACCESS TO CARE: INTERSECTING PERSPECTIVES BETWEEN CAREGIVERS AND MEN WHO HAVE SEX WITH MEN IN SENEGAL

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Context Men who have sex with men (MSM) in Senegal face a challenging socio-legal context, marked by homophobia and the illegality of homosexuality. In addition, HIV prevalence among MSM is 27.6%, 46 times greater than the one in the general population.

Methods This article describes the caregiver/MSM relationship and analyses its effects on access to healthcare by MSM. The data used are from a field survey based on observations and interviews conducted in 2019 and 2020 with 16 MSM and 10 caregivers in Dakar and Mbour hospitals. The data was subject to a thematic analysis assisted by the software Atlas.Ti.

Results The relationship between MSM and carers is ambiguous. Caregivers are torn between their professional duty to treat MSM and the cost of being stigmatised by other

colleagues so they often limit their empathy with MSM within the hospital context. MSM, trusting in the confidentiality of caregivers feel safe in the care facilities but are afraid to be seen by others. Stigmatising factors limiting access to care include : (1) fear of meeting a relative, (2) difficult relationships with technical support staff (mainly security guards), (3) HIV status disclosure and (4) potential conflicts with other MSM.

Conclusion The hospital is divided into several areas of stigmatisation. It is important to map out the MSM in their care trajectories and spaces, identify all types of staff working within them, including technical staff to enroll them in stigma reduction interventions.

Theme: Global perspectives: trust and truth in health-related settings

Day 1: Thursday 18th March – 13.35-14.55

16 UNPACKING THE 'TRUTH' ABOUT THE HEALTH GAP: DECOLONISING METHODOLOGIES, CULTURAL ARCHIVES AND THE NATIONAL ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH PLAN 2013–2023

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Truth and authority are key concepts in settler colonial knowledge systems that inform Aboriginal health policy: 'truth' about policy 'problems' and authority in who can determine policy solutions. The growing emphasis on evidence-based policy means that policymakers increasingly draw on research and western knowledge as their sources of truth and authority. In this way, policymakers construct policy as an objective 'solution' to Aboriginal health 'problems'. However, drawing upon Foucault's notion of the 'cultural archive' or 'storehouse', Linda Tuhiwai Smith (2012) shows that western research has generated representations of, and stories about Indigenous peoples (particularly 'problems') that claim 'truth' and 'authority' but are instead embedded in white, western ways of knowing and categorising the world – and serve colonial power structures.

We used Bacchi's (2009, 2015) 'What's the problem represented to be' framework to analyse 'problems' represented within the Australian *National Aboriginal and Torres Strait Islander Health Plan 2013–2023*. The Plan acknowledges that the health and well-being of Aboriginal and Torres Strait Islander people is connected to 'trauma', 'dispossession', and the 'interruption of culture'. However, in the Plan, western knowledge, described as 'clinical' and 'evidence based', is given primacy over Aboriginal and Torres Strait Islander people's 'cultural' knowledges. What is left unproblematic in the *National Aboriginal and Torres Strait Islander Health Plan 2013 – 2023* is the way this 'cultural' versus 'clinical' knowledge binary draws upon settler colonial hierarchies of knowledge, obscuring the ways even health policy serves settler colonial power structures. We conclude that, while positive, growing awareness of the role of colonisation in producing health disparities across settler and Indigenous populations has not translated into unsettling the knowledge systems upon

which policy is created. We provide some reflections on how decolonising research methodologies may also inform policy-makers seeking to 'unsettle' the truth and authority, particularly 'evidence', that influences policymaking.

17 AN INTERSECTIONAL ANALYSIS OF STORIES FROM COMMUNITIES IN PAKISTAN

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As part of its strategy, the Community Engagement Centre (CEC) – a joint venture of Indus Health Network's Global Health Directorate and Interactive Research and Development, Pakistan – collects communities' stories from program catchment populations. These include challenging, life-changing incidents and narratives of agency which offer valuable insights into organic systems and barriers as well as the nuances of power and access.

Nine stories were analysed to reveal a 'catalyst'; these stories included a person or group holding the trust of community members, that demonstrated agency to act either for themselves or their communities. These catalysts may or may not have been successful in achieving the desired change, but studying these narratives revealed the lived experiences, mechanisms of trust and dynamics of power in communities: how healthcare workers, individuals, and communities interact, utilise their agency to own positions in society, and build trust to enable change – within themselves or the larger collective. We investigated the levels at which low-resourced communities experienced challenges while aspiring towards change and whether certain social categories enabled more agency than others. To examine the stories, we developed and applied an intersectional framework that was able to dissect the stories down to their elements.

Findings yielded that classism and sexism were significant barriers for communities and individuals, while trust was a powerful facilitator for agency and action. The analysis demonstrates that conducting an intersectional analysis on these stories aids in dispelling the 'symptomised' perspective of poor communities as non-agentic and helpless in the face of difficulties. Furthermore, by understanding communities' organic responses to collective problems and health concerns, programs can integrate with existing local systems for long-term solutions.

18 TRUSTED MESSAGES? EXPLORING THE ROLE OF TRUST IN MHEALTH FOR DIABETES PREVENTION IN RURAL BANGLADESH

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Background The prevalence of type 2 diabetes is rising rapidly in Bangladesh, and there is an urgent need to engage populations in preventing and controlling diabetes. Mhealth may offer a scalable way to deliver educational advice, information and motivation for behaviour change. We conducted qualitative research to explore how a population-based mobile health